STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012129	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIR ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: February 18 and 19, 2016 Facility number: 012129 Provider number: 012129 AIM number: N/A Census bed type: Residential: 56 Total: 56 Census payor type: Medicaid: 32 Other: 24 Total: 56 Crownpointe of Anderson was found to be in compliance with 410 IAC 16.2-5 in regard to a State Residential Licensure Survey. QR was completed by 99993 on 02/22/16.	R 000		